South Carolina
Department of Disabilities and Special Needs
Service Coordination Manual

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Scope and Intended Use:

This manual is intended for use by Service Coordinators, Early Interventionists and administrative staff of all Service Coordination providers who contract with the South Carolina Department of Disabilities and Special Needs or Department of Health and Human Services (DHHS) to set forth the minimum requirements for Service Coordination.

Prepared By:

The SCDDSN Office of Service Coordination, with input and information from people eligible for DDSN services, SCDDSN staff, Service Coordinators employed by DSN Boards and qualified providers and staff who provide other services from around the state.

Technical Assistance:

Requests for technical assistance regarding Service Coordination Service should be directed to the appropriate SCDDSN District Office.

Additional Copies:

Copies of this manual can be obtained from the SCDDSN Internet Web Site (http://ddsn.sc.gov) and/or by request from the SCDDSN Office of Service Coordination (803) 898-9715.

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CHAPTER 1

INTRODUCTION TO SERVICE COORDINATION

I. WHAT IS SCDDSN SERVICE COORDINATION (also called Targeted Case Management)?

The mission of SCDDSN is to assist people with disabilities and their families through choice in meeting needs, pursuing possibilities and achieving life goals and minimize the occurrence and reduce the severity of disabilities through prevention. Consistent with the agency's mission, the intent of DDSN Service Coordination is to assist people with Mental Retardation, Related Disability, Autism, Traumatic Brain Injury, Spinal Cord Injury, and Similar Disability to access a full array of effective and cost efficient services and supports that are needed in order to avoid costly residential placement thereby making it possible for people to reside in their own homes and communities.

It is expected that SCDDSN Service Coordination services be provided in a manner that promotes:

- dignity and respect
- health, safety and well-being
- individual and family participation, choice control and responsibility
- relationships with family and friends and community connections
- personal growth and accomplishments

It is also expected that Service Coordination services reflect the principles of the agency and therefore services should:

- be person centered
- be responsive, efficient, and accountable
- be strengths-based, results oriented
- maximize potential
- be based on best and promising practices

II. THE ROLE OF THE SERVICE COORDINATOR

The Service Coordinator is responsible for coordinating services to assure that people have access to a full array of needed community services including appropriate medical, social, educational or other needed services. The Service Coordinator is responsible for identifying the person's needs and resources, coordinating services to meet those needs and monitoring the provision of those needed services. More specifically, the service coordinator's job is composed of the following core functions:

- **ASSESSMENT**

  Informal needs assessment should occur as the Service Coordinator assists the person with the Intake process to determine eligibility for DDSN services and, generally, is ongoing throughout the year. A more structured and comprehensive annual assessment and periodic reassessment of an individual is necessary to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Such assessment activities include the following:

  - Taking individual history
  - Identifying the needs of the consumer and completing related documentation
  - Gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the consumer

  Needs assessment activities may also include reviewing information for or preparing a Level of Care re-evaluation to determine if a person continues to meet the ICF/MR Level of Care or Nursing Facility Level of Care.

- **CARE PLANNING**

  Development (and periodic revision) of a specific care plan based on the information collected through assessment that includes the following:

  - Specifies the goals and actions to address the medical, social, educational, and other services needed by the consumer;
  - Includes activities such as ensuring the active participation of the consumer and working with that person (or that person's authorized health care decision maker) and others to develop such goals;
  - Identifies a course of action to respond to the assessed needs of the consumer.

- **REFERRAL AND LINKAGE**

  Referral and related activities (such as scheduling appointments for the consumer) to help the consumer obtain needed services, including activities that help link the individual with medical, social and education providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan. In the course of time during which a plan is implemented, a service coordinator may have to perform activities with a greater intensity and sense of urgency due to crisis circumstances affecting the person/family. The service coordinator may also need to advocate on behalf of the person in order to access services and supports or to protect the rights of the person or the family.

- **MONITORING or FOLLOW-UP**

  Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. Monitoring and follow-up may be with the individual, family members, service providers, or other entities or individuals. These activities may be conducted

frequently as necessary, and including at least one annual monitoring to help determine whether the following conditions are met:

- Services are being furnished in accordance with the individual's care plan
- Services in the care plan are adequate to meet the needs of the individual
- There are changes in the needs or status of the eligible individual. If there are changes in the needs or status of the individual, monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with provider.

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

(DDSN- determining if the plan is effective; activities may include face-to-face contacts with the person receiving services and or legal guardian; home visits; evaluation of services as they are being provided; mail correspondence, telephone calls, e-mail and fax correspondence with the person, legal guardian, family, providers of services and supports received and appropriate others; quarterly plan reviews; and monitoring as required by the Mental Retardation/Related Disability (MR/RD) Waiver, Pervasive Developmental Disorder (PDD) Waiver, Community Supports (CS) Waiver, and Head and Spinal Cord Injury (HASCI) Waiver. (Please refer to the PDD, MR/RD, CS and HASCI Waiver Manuals/guidelines for more information about monitoring requirements.)

III. KEY SKILLS FOR SERVICE COORDINATION

Service Coordinators must possess many skills and abilities in order to provide quality services and to effectively perform the core functions of the job. The key skills for Service Coordination include those interpersonal skills that are needed to establish relationships with others including:

The ability to actively listen– to actively seek information from someone; to hear what and how something is being said; to communicate with and learn from another or from group reviews, written feedback, personal outcome interviews, etc.; to respect people served by allowing them to decide when and where communication takes place.

The ability to respond – to take information received about a person and assist in finding resources/services/supports to respond to needs; to respond to immediate requests (i.e. respond in a respectful and timely manner upon verbal requests, to respond to telephone calls immediately, respond in providing information to others, making timely referrals, etc.).

The ability to respect the person's perspective and experience – to be empathetic; to seek to understand the person before making recommendations for services; to give the person the same dignity, rights, and honor as other members of the community; assist people in exercising their rights that will facilitate personal goals.

The ability to resolve conflicts - be an effective mediator.

The ability to provide relevant information - to provide information that is concrete and specific enough to enable people to make informed decisions; facilitate visits, observations and experiences for people so informed choices can be made; having knowledge of local, state, federal, and community resources to be able to offer an array of choices.

The ability to promote natural support relationships – to assist in promoting or developing relationships that enable and encourage people to identify their goals and improve their lives; assist in establishing a support network that goes beyond typical/paid services/supports.

The ability to manage competing priorities – to be able to manage work where there are unpredictable situations such as when needs develop, crisis situations occur, etc.

The ability to think critically – to be able to think about situations and respond to them or provide solution, to make professional judgments based on an array of information

IV. PERSON-CENTERED APPROACH AND PLANNING

A person-centered approach is a strategy that, when employed, allows the Service Coordinator to learn about a person with disabilities in order to support that person to create a lifestyle that allows him/her to fully participate as an active citizen who contributes to the life of the community. A person-centered approach is more than a meeting; it is a system of beliefs and values employed when people work together (person with the disability, legal guardian, friends, staff, etc.) to assist with the creation of a lifestyle based on the person's needs, interests and preferences. In other words, the focus of person-centered approaches should be to assist a person receiving services to have a meaningful life as they define it, which requires more than merely accessing services. All planning that occurs on behalf of people served should be person-centered. The group of people assembled to work with the person/legal guardian is commonly known as the 'circle of support,' which includes people that the person receiving services/legal guardian desires to be involved in the process. A circle of support might include the person served, friends, neighbors, family, Service Coordinator, service providers, other professionals who work with the person being served and any other natural supports that are meaningful in their life.

Today many people with disabilities are seeking more control over their lives. Their focus is on choice and self-determination in all areas of life, but especially in those that affect friends, neighbors, home, work, finance and leisure. Ideally, people receiving services should be directing their lives. People with disabilities have the right to determine their personal goals, the responsibility to share those goals with professionals when assistance to attain them is desired, and the right to decide which services and supports they want to meet their needs. These services and supports include natural and community resources, as well as traditional agency services.

Some people with disabilities are capable of identifying and obtaining supports and services on their own. Others have family members, friends, and other natural supports to help them. However, many people with disabilities and their families prefer professional assistance in developing a plan, which is part of the type of assistance that Service Coordinators can provide. Service Coordinators help people receiving services explore what they want and need in life. They work in partnership with the person/legal guardian to develop, implement, monitor and maintain the person's plan. Service Coordinators assist people to attain the highest quality of life as defined by them. Two activities of Service Coordination that are especially critical deal with protecting and upholding a person's human and civil rights and assuring their health and safety needs.

While the Service Coordinator is responsible for the development and implementation of the annual plan, it is the person receiving services and/or legal guardian who guide the Service Coordinator in identifying and fulfilling needs. In order for this to happen, the Service Coordinator must develop and maintain a relationship and partnership with the person receiving services and/or legal guardian, come to know the person's personal goals and needs, and be able to advocate for the person. It is this personal relationship with the person receiving services and/or legal guardian, and the positioning of the person in the driver's seat that is at the heart of person-centered planning.

IMPORTANT NOTE

Beginning March 9, 2010, the primary case record for service coordination consisted of a hardcopy paper file AND any electronic service notes that were created prior to official implementation of the CDSS service note module on July 1, 2010. Once the service note module was implemented , it was required that all service notes be entered on the CDSS service note module. The authenticity of these notes was validated by electronic signature. Also, as of July 1, 2010, electronic transmission of service note data to DDSN began and DDSN began to determine which notes support billing to Medicaid.

Beginning November 2, 2010, the DDSN Needs Assessment, the Support Plan, Add Needs, any Needs/Service/Intervention changes to the Support Plan, and Monitoring in the Consumer Assessment and Planning module of CDSS will also be electronically signed and will be considered the legal documents for the person's primary case record.

Service coordinators who do not have a PIN to activate their electronic signature for use with service notes, the assessment, the plan, add need, need/service/intervention change, and the monitoring may obtain one by contacting DDSN's Helpdesk.

SCDDSN electronic records are in compliance with the Uniform Electronic Transactions Act. (S.C. Code Ann. §26-6-10 et seq.)

Because there will be an indefinite period of overlap in which paper records will be created and/or will exist concurrently with electronic case records, these standards and guidance have been modified in order to reflect the use of both.

For training or guidance on how the electronic service note system works, log on to the CDSS portal page and click on the following links in order.
R2D2>Documents>Business Tools>Videos>Application Training>Service Notes

STANDARDS

I. Staff

Standards	Guidance
A. Service Coordination services shall be rendered by qualified staff.	
1. Service Coordination Supervisors (SCSs) must hold a Master's degree in Social Work or a related field from an accredited university or college and have at least one year of experience in programs for people with disabilities or have at least one year of experience in a case management program and demonstrate knowledge of disabilities **OR** Hold a Bachelor's degree in Social Work or a related field from an accredited university/college and have at least 3 years of experience working with people with disabilities or have at least 3 years experience in a case management program and demonstrate knowledge of disabilities.	Requests for exception to the required Service Coordination Supervisor qualifications can be made to the Office of Quality Management, SCDDSN. Activities of Service Coordination Supervisors, Service Coordinators and Service Coordination Assistants who do not meet qualifications are NOT reportable. There are no exceptions. A Service Coordination Supervisor may perform any and all of the required functions of a service coordinator ONLY if they meet the requirements of a service coordinator. A person with a family relationship to a consumer may not provide service coordination to that consumer.
2. Service Coordinators(SCs) must hold at least a Bachelor's degree in Social Work or a related field from an accredited college or university **OR** Hold at least a Bachelor's degree in an unrelated field from an accredited college/university AND have at least one (1) year of experience in programs for people with disabilities or have at least one in a case management program and demonstrate knowledge of disabilities.	

Standards	Guidance
3. <u>Service Coordination Assistants (SCAs)</u> must hold a high school diploma/GED (or higher) and must have the skills and competencies sufficient to perform the tasks to which they may be assigned or the capacity to acquire those skills and competencies.	Activities of Service Coordination Assistants whose documentation is not co-signed by a Service Coordinator/ Service Coordination Supervisor are <u>NOT reportable</u>. The activities of a Service Coordination Assistant are primarily administrative or clerical in nature. Duties performed by an Assistant in support of Service Coordination may include, but are not limited to, the following: • General clerical duties such as filing, copying, faxing, typing, etc. • Identification of resources to meet individuals' needs. • Responding to requests for information and referral. • Accompanying Service Coordinators to interagency staffing, intra-agency staffing, IEP meetings and other meetings. • Gathering records and information and submitting eligibility requests and requests for Level of Care evaluations including tracking service delivery due dates. • Gathering records and information to begin completion of the Service Coordination Annual Assessment. • Identification and recruitment of caregivers. • Reviewing and reconciling waiver budgets and expenditures. • Monitoring consumer satisfaction **Service Coordination assistants may not:** • Complete CAP Assessments • Develop or complete CAP Service Plans • Complete an Add Need

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	• Complete CAP Need/Service/Intervention Changes • Complete CAP monitoring of the plan • Complete electronic service notes • Attend interagency staffing and meetings (though a Service Coordination Assistant may accompany.) • Attending court ordered hearings or other legal proceedings (though a Service Coordination Assistant may accompany.) • Develop waiver budgets and revisions. • Complete re-evaluations of ICF/MR Level of Care • Have a caseload of Level I DDSN eligible people. (Assistants may have a caseload of non-eligible people during Intake.)
B. Each Service Coordination Assistant, Service Coordinator, or Service Coordination Supervisor must be an employee of SCDDSN, a DSN Board, or a SCDDSN qualified Service Coordination provider	
C. Each Service Coordination provider shall maintain: **1.** a current list of staff members **2.** a signature sheet for service coordination assistants, service coordinators and service coordination supervisors which includes all signature and initial variations used by those staff **3.** a credentials folder for each staff member which includes: **a.** Resume'/Equivalent Application **b.** Certified copies of transcripts from an accredited university /college **c.** Training records **d.** Job description	

Standards	Guidance
e. Annual performance evaluations and background checks according to 406-04-DD, Criminal Record Checks and Reference Checks of Direct Caregivers	
D. Service Coordination staff must be trained **1.** Service Coordination staff (hired after November 2, 2010 must be provided training at a minimum in the following topic areas as a DHHS-approved curriculum and must demonstrate competency in these topics: **a.** SCDDSN Service Coordination Standards including, but not limited to Assessment, Care Planning, Referral and Linkage, Monitoring or Follow Up and reportable and non-reportable activities including service note documentation. **b.** Basic service coordination skills **c.** SCDDSN policies and procedures applicable to Service Coordination **d.** Rights of consumers **e.** Local, state, and national resources that comprise the system of care for DDSN's target populations. **f**. Access to and use of CDSS/STS **g**. Nature of MR/RD, Autism, traumatic brain injury, spinal cord injury and similar disability (as appropriate) **h**. Abuse and Neglect	Records must reflect that information presented in training was comprehended by the Service Coordinator. Providers, at their discretion, may require service coordination staff to have additional training beyond the minimum established by these standards in order to ensure knowledge and skills competency. Training is not limited to a classroom setting and may include the following activities if they are related to the professional practice of service coordination and services to persons with disabilities: • Shadowing an experienced Service Coordinator or other professional staff • One on one instruction (not routine supervision) by a supervisor or other designated staff • Site visits to disability programs and services of other community service providers for the purpose of understanding the disability community and its service provider network

Standards	Guidance
i. Confidentiality **2**. Prior to performing a specific job duty, newly employed Service Coordination Assistants will have training specifically related to each of their job duties and responsibilities. **3.** After the first year of employment, all Service Coordination staff must receive a minimum of 12 hours of training annually on topics related to the provision of Service Coordination services and **must include training on Abuse and Neglect and Confidentiality** . .	"Topics related to the provision of Service Coordination services" (Item D. 3. in left column.) includes content which supports or enhances core job functions and the duties and responsibilities of Service Coordination. Some of these topics may be found in 567-01-DD, Employee Orientation, Pre-Service and Annual Training Requirements. Except for the required annual topics of D. 3, specific training topics after the first year of employment are determined at the discretion of and according to the perceived needs of the provider. These topics may include but are not limited to: • DSN policies and procedures • Effective Communication • Gathering Information for planning • Community Resources and Agency Interface • Time and Stress Management • Person-centered philosophy and concepts • Analyzing, Organizing, and Managing Information including both paper and electronic records • Sensitivity to individual/family uniqueness • Advocacy, Negotiation, and Problem-Solving • Pertinent Legislation • Self-Advocacy and Self-Determination • Assistive Technology and AT resources • Working collaboratively with others • Documentation and Preparing Written Documents • Crisis Intervention Management • Condition/Diagnosis- Specific Information • Teamwork and Leadership • Measures of Effectiveness of Case Management • Risk Management

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	• Healthcare Guidelines and Screening • Emergency Planning for People With Special Needs
E. Service Coordination providers must be accessible to people served and must have a system in place which allows people served to receive assistance with any crisis situation 24 hours a day, 7 days a week.	ACCESSIBILITY: If necessary, a back-up on-call system may be implemented which will allow immediate accessibility for people receiving services. People receiving services and providers should be encouraged to call 911 in the event of a medical or police emergency; however, Service Coordination providers must still be accessible to provide assistance as needed. It is acceptable to have a general on-call number (beyond working hours) provided there is a response to crisis calls within 2 hours.

II. Duties, Responsibilities, and Service Content (Core Job Functions)

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	NOTE: **<u>As of July 1, 2010, INTAKE</u>, <u>ADVOCACY</u>, <u>CRISIS INTERVENTION</u> AND <u>CONSULTATION/COLLABORATION</u> WERE NO LONGER CONSIDERED SEPARATE AND DISTINCT CORE FUNCTIONS OF SERVICE COORDINATION. HOWEVER, EACH OF THOSE ACTIVITIES MAY RESULT IN A REPORTABLE SERVICE COORDINATION ACTIVITY WHEN COMPLETED IN CONJUNCTION WITH A CORE FUNCTION. FOR EXAMPLE, A PARENTAL INTERVIEW DURING INTAKE MAY RESULT IN THE IDENTIFICATION OF NEEDS OR THE EARLY ELEMENTS OF A PLAN FOR THE PERSON. IN THIS CASE, INTAKE IS THE CONTEXT IN WHICH ASSESSMENT OR PLANNING OCCURS. SERVICE NOTE CONTENT SHOULD DESCRIBE THE ASSESSMENT OR PLANNING IF THE NOTE IS TO REPRESENT REPORTABLE ACTIVITY.**
A. INTAKE **1.** Service Coordinator or agency designee must make contact with the applicant/legal guardian within 7 business days of the provider receiving the referral in the unassigned bucket from a screener **2.** Appropriate intake forms must be provided to, explained to, and signed by applicants for DDSN eligibility or their legal guardians. **3.** Social History information must be secured and documented during intake. **4.** When an eligibility packet is completed, it must be sent to the Consumer Assessment Team (CAT) within 5	Intake is the combination of activities that lead to a determination of eligibility or ineligibility for DDSN services. Intake begins after a person is screened in and makes their first choice of an SC/EI provider. The date of this choice establishes the <u>Case Open Date</u> on CDSS. The screener then makes the transfer to the chosen provider accepting the referral. If the screening disposition to the chosen provider indicates that the applicant has also requested waiver services, a waiver slot allocation request will be processed according to guidance of the applicable waiver manual. Intake ends with notification to the applicant/legal guardian of the eligibility decision, including any appeals that might be initiated. If a person's record has been closed after previously being served by DDSN, all Intake standards and guidance apply if

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business days of completion. **5.** If eligibility is not determined within 90 calendar days of the case open date, documentation must be available to show that the applicant was notified of the reason for delay and informed of their movement to Level II service coordination. **6.** If eligibility has not been determined within 180 calendar days from case open date, there is documentation in the primary case record to show that options were discussed with the applicant. **7.** Documentation is in the file showing the applicant was notified of the DDSN eligibility determination.	they again seek DDSN services. Because contact must be made with the person/legal guardian within seven (7) business days of referral to the service coordination provider of choice, a referral should not be left indefinitely in the "unassigned bucket" in the CDSS. SCAs may assume all intake duties provided the SC or SCS signs off on manual service notes or completes electronic service notes reflecting intake activities. The completion of the SCDDSN Needs Assessment in the Consumer Assessment and Planning module of CDSS does not begin until eligibility has been determined and the person has been moved back to Level I by District staff as a result of the service coordination levels assessment. If the person is not moved to Level I, no comprehensive needs assessment or plan is required. However, the comprehensive needs assessment in CAP must be completed prior to completion of the CAP plan. During **Intake** as records are gathered for eligibility determination, it is a good time to begin an informal assessment of need and even to think ahead to the plan. REQUIRED INTAKE FORMS – The required intake forms include the following: • **SCDDSN Service Agreement and Permission to Evaluate**— A valid, signed and dated SCDDSN Service Agreement form must be in the primary case record before a Service Coordinator may begin to provide services. • **Release/Request for Information**—These forms are required before a Service Coordinator can contact providers of services or request information regarding the applicant. • **HIPAA Acknowledgment form** • **Genetic Services Consent Form** (for MR/RD eligibility applicants only) The **Acknowledgement of SC/EI Choice form** does not have to be signed by the applicant/legal guardian after their selection of an SC/EI provider to begin the intake process

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	for eligibility. However, the screener will offer the person a choice of SC/EI providers to begin intake for eligibility. Required intake forms must be signed by the eligibility applicant if 18 years of age or older and not adjudicated incompetent. If the applicant is under age 18 or adjudicated incompetent, the legal guardian must sign the intake forms. (Note: Official documentation of legal guardianship should be obtained and kept in the primary case record at all times.). New intake forms must be obtained when the person reaches age 18 and is not adjudicated incompetent, if there is a name change of the person and/or legal guardian, or if there is a change in legal guardianship. New required Intake forms (excepting Request for Information form unless needed) must be in the primary case record of Level I Service Coordination recipients **within 90 calendar days** of the person's 18th birthday or other event that requires a new form. New intake forms need to be obtained when a person returns to DDSN for services after their file was previously closed. If a person turns 18 or there is a change in guardianship while they are on Inactive status or receiving Level II Service Coordination, it will not be necessary to update the required forms until the person moves to Level I Service Coordination status (When a person is moved to Level I, required forms must be updated within 90 calendar days of the date of movement.) Release/Request of Information forms will only need to be signed as needed or requested. If a person is unable to consent according to 535-07 DD, Obtaining Consent for Minors or Adults, then consent must be obtained consistent with this directive. If the person is able to consent but is unable to write their signature, their "Mark" is acceptable. This "Mark" must be witnessed by signature on the same form. Circumstances of the Mark and witness should be included in the service notes.

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	Social history is to be documented on the Consumer Information Summary (CIS) that is provided to CAT as part of the intake packet The CIS should also be retained in the case record. Required paperwork to submit to the CAT: • Consumer Information Summary (CIS) • Functional Assessment and Background Information (FABI) – for HASCI Division referrals only • Medical reports/records • Psychological examination reports • Other information supporting diagnosis and any functional limitations TIMEFRAMES: DDSN eligibility should be pursued as quickly as possible without regard to the preceding Best Practice (not mandatory) time frames. For those people in critical or urgent referral status, the SC/SCA must document accelerated and continuous attempts to obtain an eligibility decision in less than the maximum timeframe. If an eligibility decision has not been made within 90 calendar days of the case open date, the SC/SCA will: • discuss with the applicant/legal guardian the reasons for delay in eligibility • inform the applicant/legal guardian of movement to Level II Service Coordination and any implications to that change • document the discussion in the service notes • inform the SCS of reasons for the delay • continue to work with the applicant/legal guardian to complete the eligibility packet for an additional 90 calendar days unless otherwise indicated by the applicant/legal guardian No Service Coordination activity is billable to Medicaid after 90 calendar days in Intake though service notes should continue to document core function activity. If eligibility is delayed due to the SC/SCA being unable to locate or contact the applicant/legal guardian, the SC/SCA

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	will meet with the SCS to discuss the case and determine if intake should be extended or the case closed. If eligibility is not determined within 180 calendar days of the Case Open Date, the SC/SCA will discuss the reason for delay with the applicant/legal guardian, choices of further extension or case closure, and the option of re-applying if services are needed in the future. Any discussions and contacts with the applicant/legal guardian during the intake process, along with justification for any extensions, must be documented in service notes. If an extension is chosen, the Service Coordinator will notify the SCS, who will notify the Executive Director. If a request for a DDSN HCB Waiver has been made for someone later found not eligible for services, the appropriate DDSN Waiver Coordinator should be involved regarding notification of Appeals. The Intake worker will notify the applicant of the eligibility determination and will document the notification in service notes. If an applicant is eligible for services through DDSN and is returned to Level I by the District Office, the Service Coordinator should continue/begin the assessment and planning process. If an applicant is not found eligible for services, written notice of the eligibility decision will be provided to the applicant within five (5) business days of the provider's receipt of the eligibility decision. The notice will be in writing and will include information on the right to appeal eligibility denial and the procedures for appeal. Upon request of the applicant, the Service Coordinator must read or explain the eligibility decision and appeal procedures to the applicant if eligibility is denied. The Service Coordinator will also provide information and referral to appropriate community resources or other agencies based on the person's disability and needs.
B. ASSESSMENT (CORE FUNCTION) **1.** A comprehensive assessment of the person's needs must: **a.** be completed prior to the initiation of the Plan	NEEDS ASSESSMENT: Needs assessment may include a wide range of activities to obtain and to review information to determine a person's personal goals and needs in order to develop an accurate and effective Support Plan. Needs assessment is based upon an evaluation of the person's environmental, economic, psycho-social, medical, and any other factors

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b. be completed at least annually **c.** be completed using the Consumer Assessment and Planning (CAP) module of the Consumer Data Support System (CDSS) **d.** be completed when there is a crisis (crisis intervention) or when interventions are needed to address specific and identifiable problems (regular intervention) **2.** A Level I/Level II assessment must be completed NO MORE THAN 10 business days prior to: a. transfer from Early Intervention to Service Coordination b. movement to Level II by a provider c. a request to move from Level II to Level I by a provider.	that impact the person. Personal observations and interviews are important elements of needs assessment, especially during home visits, other face-to-face contacts, and during contacts with providers of services/supports or with any other people involved in the person's life. Beginning November 2, 2010, the Needs Assessment will be electronically signed, titled, and dated. The expectation is that if the person has had a **Life Plan** completed, the Life Plan should be considered part of the overall assessment of needs for a person and noted as one of the documents/records that was reviewed. Personal goals may or may not be included in the service coordination plan but should always be considered for inclusion. The comprehensive needs assessment within CAP must be completed prior to completion of the plan. This same assessment may need to be completed more than once a year particularly if the person/family is in crisis or if any major changes occur in the life of the person or at any time the service coordinator considers it necessary for appropriate planning. Any time an Assessment is completed, a new Plan in CAP must be completed or the Assessment must be terminated. Ongoing informal assessment will occur throughout the year during regular contacts to assure that a person's goals and needs are still consistent and are accurately reflected on the Plan. IDENTIFYING/UPDATING NEEDS – Current needs may be identified during the year which may require previously identified needs to be discontinued or revised. All newly identified needs, as well as previous goals/needs that are revised or discontinued must be noted on the Plan by using the CAP module of CDSS and documented in the service notes. Updates are not to be made to the SC Annual Assessment that is completed in the CAP module. REGULAR INTERVENTION*:* Time spent with the person/legal guardian to deal with specific and identifiable problems which require the Service

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	Coordinator's guidance. The problem does not place the individual in jeopardy and the timeframe is not immediate. CRISIS INTERVENTION: Immediate response to specific needs which, if not met, would put the person in jeopardy. Crisis Intervention involves activities to respond to any emergency, life-threatening circumstance or health and safety issue arising in the life of the person which requires immediate assessment and resolution. Steps in addressing problem/crisis situations: • **Assessment of problem/crisis**- gather information in the event of a crisis situation with assistance from the person affected, family members, other current providers or others involved in order to identify the immediate problem and any potential health and safety hazards which may affect the person. • **Addressing problem**- identify and implement steps to address the crisis situation in the best and safest way possible • **Follow-up/monitoring-** follow up to assure that all necessary actions/services were provided, and to monitor if the crisis is resolved or if any additional action or services may be required . **REPORTING OF ABUSE/CRITICAL INCIDENTS** In the event of a finding of or an allegation of abuse or the occurrence of a critical incident as defined by DDSN policy, the Service Coordinator and/or the provider involved is responsible to complete a Report of Abuse or Critical Incident (per DDSN directive 534-02-DD). Service Coordinators will monitor any circumstances that are the subject of a report of abuse or critical incident involving the person with the person to ensure that they are safe and well. The service notes will show that the Service Coordinator monitored and/or took appropriate actions to implement recommendations in final written reports of abuse and critical incidents. SERVICE COORDINATION LEVEL The Service Coordinator must assess the person's need for

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	ongoing Service Coordination. Once the person is assigned to a Service Coordination Level I, the level should be reviewed annually during the assessment/planning process. A person's Service Coordination level should also be reviewed when needs significantly change or when the person experiences a major life change. The Level I/Level II Service Coordination Assessment is not required to be completed at each subsequent annual review but the status must be reviewed and documentation should be included on the Plan. (Please refer to the Levels of Service Coordination, 700-04-DD) Documentation of Level I SC status should be indicated on the first page of the Support Plan. Movement of someone from Level II to Level I Service Coordination can occur only with approval from DDSN. A District Office or the HASCI Division will issue the approval according to procedures defined by those offices.
C. CARE PLANNING (CORE FUNCTION) **1.** A Plan must: **a.** be completed within 45 calendar days of movement from Level II to Level I for children not DDSN-eligible and who have been awaiting enrollment in the PDD waiver **b.** be completed within 45 calendar days from date of transfer for those moving from Level II to Level I Service Coordination, or moving from Early Intervention services to Service Coordination **c.** be completed prior to the delivery of DDSN operated Home and Community –based Waiver services **d.** be completed annually (must be completed every 365 calendar days	Care planning will identify and document the personal needs of the person receiving services and the services and supports necessary to address them. Personal goals identified through a Life Plan or by other means may or may not be included within the service coordination plan. However, the service coordinator is expected to consider personal goals and preferences though they may or may not be appropriate for or possible to include in the completed plan. Care Planning, Referral and Linkage and other core functions by the Service Coordinator will be suspended if the consumer is placed on Level II Service Coordination or if the case is closed). At the time of eligibility determination, the person will automatically be moved to Level II Service Coordination. If they meet the requirements for Level I Service Coordination according to the Level I/Level II Service Coordination Assessment, they can be moved back to Level I by District Office. Thereafter, any time the person does not require Level I Service Coordination according to the Level I/Level II Service Coordination Assessment, the person must be placed on Level II Service Coordination.

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NOTE REGARDING PLAN TIMEFRAMES: **To be in compliance with timeframes, both the plan completion date and the data entry date for completing the plan in CAP should be within required timeframes (45 days, 365 days, etc.). Beginning November 2, 2010, the date that a plan is completed on CAP will become the date of the service coordinator's electronic signature AND the effective date of the plan. Service coordinators will not be able to enter the effective plan date.** **e.** be signed, titled and dated by a credentialed Service Coordinator on the first page of the plan on CAP **f.** be signed (or initialed), titled and dated on the top of every page any time after November 2, 2010 that a circumstance requires completion of a plan entirely on paper such as the anticipated transfer of an ICF/MR resident. **g.** be placed in the person's file within 10 business days of the Plan completion date if completed prior to implementation of the plan electronic signature or if completed entirely on paper. Upon implementation of the plan electronic signature (plans completed on or after 11/02/10), it is not required that the current plan be in the file **h.** reflect if consideration is being given to the need for contact in excess of the minimum requirements **i.** include information about the person's plan for responding to emergencies	The plan must be completed before PDD Waiver services can be authorized. If a person has requested a DDSN operated Home and Community Based Waiver slot and is awaiting that slot in critical/urgent status, it is in the best interests of the consumer and it is Best Practice to complete the plan as soon as necessary within timeframes. WHEN A SERVICE COORDINATOR IS NOTIFIED THAT A RESIDENT IS TRANSFERRING FROM AN ICF/MR to a less restrictive community setting, the Service Coordinator should begin assessment and planning prior to the transfer. The Service Coordination Plan must be in place prior to authorizing Waiver services (Before the transfer is made, the plan can only be completed on paper. After the transfer, the plan should be keyed into the CDSS CAP module. For those receiving Level I Service Coordination, a plan must be completed <u>within</u> 365 calendar days of the last plan date. For example, if a person's plan date is 7/31/2007, the next plan <u>must</u> be completed on or prior to the 365th day from 7/31/2007, i.e. on or prior to 7/30/2008. Each person/legal guardian must be offered the opportunity to meet with the Service Coordinator face-to-face for the purpose of completing the annual Plan. Documentation of the person's desires with regard to a face-to-face for plan development must be recorded in the service notes. If a plan meeting is desired, the person/legal guardian may request that others of his/her choosing be invited to this meeting. Meetings should be held at times and locations that are reasonable (within the county for which the person resides and/or the county where the chosen Service Coordination provider provides services) and convenient for all parties. CHANGES TO THE PLAN The Service Coordinator will ensure that adding new needs and needs/service/intervention changes to the Plan are completed in the CAP module. Updates of social and demographic information must be made in the CDSS and the file within 72 hours of notification. Updates to the CAP

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j. address identified health and safety needs for persons placed in DDSN residential settings or in contractual residential settings. **k.** be current at all times **l.** document emergency plans **2.** Documentation must reflect that a choice of Service Coordination provider is offered annually during planning to those who are DDSN eligible and Level I **3.** Transfer to a new service coordination provider must occur on CDSS and the file be in the mail or otherwise delivered within 10 business days of the request	Needs Assessment and any changes to other sections of the Support Plan should be referenced in service notes. The needs assessment cannot be updated electronically in CAP after a plan is completed. Beginning November 2, 2010, Add Needs and Needs/Service/Intervention changes will be electronically signed, titled, and dated. A copy of the completed plan must be provided to the person, parent, legal guardian or legal representative and documented in the service notes. The service coordinator must document that the person, parent, legal guardian and/or legal representative participated in the planning process. Documentation may be in the form of a plan meeting sign-in sheet when the above persons were present and/or documented in service notes describing participation in the planning process. Service note documentation that the completed plan was provided to the person, parent or other legal representative is also indicative of participation in planning. Participation in planning may also be documented as participation in completion of the Assessment. It is not necessary for Service Coordinators to sign all Plans received as a result of transfers from one provider to another or one caseworker to another. Additional contact beyond the minimum (quarterly) must be considered at least annually and, if additional contact is needed, the need must be included on the Support Plan. Additional contact may mean an increase in the frequency of the contact (i. e. contact more frequently than quarterly for some or all services/supports), an increase in the intensity of contact (i. e., face-to-face contact at regular intervals rather than contact annually) or a combination of increased frequency and intensity. When considering the need for additional contact, consider if circumstances such as, but not limited to, the following exist: • The person does not effectively communicate problems or concerns to others. (Does the person

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	make needs known verbally or through sign language? Can the person indicate such things as how he or she got a bruise or how his/her money was spent?) • The person is physically dependent on others for basic care. (Does he/she have any capacity to physically protect him/herself?) • The person engages in behaviors that are mentally and physically challenging for caregivers. (e.g., hitting, spitting, kicking, name calling, taunting, cursing, extreme uncooperativeness, etc.) • The person does not have regular contact with family or friends who are not paid agency employees. (If family and friends are available, do they assist the person in decision-making or advocate on his/her behalf and in his/her best interest?) The presence of circumstances such as these above may indicate an increased vulnerability and, therefore, indicate a need for increased contact. Emergency Plans (for what to do in event of an emergency) must include, but not be limited to, the following components: <u>For people residing in SCDDSN sponsored residential settings</u>, • a statement regarding the location of the detailed emergency disaster plan <u>For people in all other settings (including non-DDSN sponsored residential settings),</u> • plans in the event of an emergency/natural disaster or loss of primary caregiver • identification of transportation services/supports to be used and/or how the person will be transported • where the person will evacuate to if an evacuation is required Updates of Emergency planning information during the course of a plan year will be noted in the service notes and updated during annual plan development on the plan. <u>Generally, no services should be authorized or provided in</u>

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	the absence of a current Plan. Exceptions include the provision of service coordination within time frames for plan development and state funded services may possibly be provided for: • people who are moved back to Level I after eligibility determination • people coming from EI to Level I SC • people receiving Level II Service Coordination. Service coordinators must sign plans for them to be valid. A current manually signed plan must be maintained in the file at all times or there must be a completed current plan in CAP with an electronic signature. Payment for any services that are being provided for a person without a current/valid Plan may be subject to sanctions/recoupment when identified through quality assurance reviews. If a person has a **Life Plan** then the Service Coordinator must review and consider the recommendations. Although personal goals may or may not be addressed as a formal need on the Service Coordination plan, the Service Coordinator will at least advocate for all service providers to address and incorporate personal goals into all service plans. Life Planning is not necessarily linked to the Service Coordination Plan and may be provided at any point during the Plan year. Life Planning is a separate service used to assist in identifying personal goals and priorities. The person/legal guardian should participate in developing the Service Coordination Plan and have an understanding of its content. Documentation will be in the file to show the Service Coordinator has discussed the completed plan with the person/legal guardian and that they agree or disagree with its contents and, if applicable, whether an appeal might be anticipated. During annual planning, Service Coordinators must inform a person/legal guardian of all available Service Coordination or Early Intervention providers and offer them a choice of providers. If the person does not choose to change providers at the annual review, it will not be necessary to obtain a new "Acknowledgement of SC/EI Choice" form. The current Service Coordinator will

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	document that a choice was offered. Service coordinators should be responsive to a request for a change in service coordination provider with documentation that choice was offered.
D. REFERRAL AND LINKAGE (CORE FUNCTION) **1.** The plan must be implemented. **2.** Service Coordinators will respond to areas of identified need and must begin implementation of activities to address needs within 10 business days from the date of identification unless otherwise specified in the annual plan. **3.** When a referral is made by the Service Coordinator to a new service provider (for both new and ongoing services), the service coordinator will follow up with the consumer and the service provider after the first service delivery date to determine whether the service and provider appear appropriate to address the need. **4.** The Service Coordinator must ensure that the person's freedom of choice of providers is maintained including choice of Service Coordination provider. These choices must be documented. **5.** Documentation must reflect a choice of Service Coordination provider was offered: a. annually during planning to those who are eligible and Level I. b. when the person requests a change of provider **6.** At initial planning and annual planning thereafter, all people receiving Level I Service Coordination will be provided an	A Plan is implemented when a Service Coordinator: • helps the person to obtain needed services/ • acts to develop new resources if none are currently available • acts to maintain and coordinate services and supports currently received • acts to link the person with providers of services or programs that are capable of meeting identified needs As the person's situation changes, the needs, services and supports identified in the Plan for the person served may also change. IDENTIFYING/DEVELOPING RESOURCES AND REFERRALS – Once the Plan is completed and approved, the Service Coordinator will assist the person receiving services/legal guardian in identifying appropriate providers for needed services and arranging for services. Follow up to new referrals for services will occur when circumstances require but no later than the next due quarterly monitoring to assure that the service is adequately addressing the persons need. The Service Coordinator will advocate for developing new resources if needed services are not available. As needs are identified during planning or throughout the year, Service Coordinators will respond to and provide assistance in meeting the needs. "Respond to and provide assistance" is not considered to be the actual act of completing *all* activities in addressing needs but rather is defined as making contacts with the person and/or other appropriate individuals to coordinate activities in meeting needs. CONSULTATION/COLLABORATION is the sharing of

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estimate of the cost of services they receive. **7.** People to receive Level II Service Coordination will be informed at the time of notification of movement to Level II that an estimate of the cost of services they receive, <u>if any,</u> is available upon request. **8.** All people receiving Level I Service Coordination will be provided information on what is and how to report incidents of abuse, neglect and exploitation annually.	information between and joint problem-solving with service providers and other professionals to gain a better understanding of a person's current situation and to determine the best course of action to address identified personal needs. Consultation/Collaboration is an important, if not essential, element in all of the core functions of service coordination. Coordination by the Service Coordinator may include, but is not limited to: • Coordinating access to all necessary services available to people with disabilities (including services available to Medicaid recipients and available within the community) • Assists people in obtaining <u>all</u> needed services identified in the Plan, including all services covered by Medicaid. • Coordinates services from multiple agencies that are required to meet individual's needs. May attend public school meetings, community support meetings, and meetings with any organization or person on behalf of the person receiving services(if invited and notified of those meetings) • Coordinates access to primary care physicians, local DSS programs, county health departments, and other local service providers. • Coordinates services within local DSN programs or contracted private providers and effects transfers to appropriate services within DSN programs or contracted private providers which are indicated by the person's Plan. • Arranges needed family support services/funds if indicated as a need in the Plan. • Arranges/coordinates for a person's access to a primary health care physician and access to other health care providers based on a person's healthcare needs. • Authorizes services under a DDSN Home

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	and Community based Waiver when appropriate. • Coordinates transportation to medical appointments through the county DSS and other local providers. CHOICE OF PROVIDERS – The person receiving services or legal guardian must be given a choice of all qualified providers of services and supports. The initial choice of provider is offered by the screening agency prior to intake beginning. Choice should be offered at a minimum of annually during plan development, any time the person receiving services or legal guardian requests a change in services or providers, or when a new need is identified. It must be documented in service notes that a choice of providers was offered and what the person receiving services/legal guardian's choice was. If there is only one potential provider for a particular area, the person receiving services/legal guardian must be informed and the Service Coordinator must document this discussion in a service note. If the person does not choose to change providers at the annual review, it will not be necessary to obtain a new "Acknowledgement of SC/EI Choice" form. The current Service Coordinator will document that a choice was offered. Service coordinators should be responsive to preferences of the person/legal guardian and to a request for a change in <u>any</u> service provider. Documentation must reflect that a choice was offered**.** AUTHORIZING SERVICES – Once appropriate providers have been identified, and the Plan and funding have been approved, the Service Coordinator will send the appropriate authorization or referral form to the provider notifying them they are authorized to provide a particular service. For MR/RD, PDD, CS and HASCI Waiver services, the appropriate Waiver authorization form should be used and a copy forwarded to the provider <u>prior</u> to the start date of services. (Refer to MR/RD, PDD, CS or HASCI Waiver guidelines for appropriate forms). For people receiving

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	State-funded Day Services, the Service Coordinator will use the "Referral for State Funded Day Services" located in R2D2, Business Tools with service coordination forms. People receiving Level I Service Coordination services will be provided an estimated, not actual, cost of services. The estimate of cost is based on the current array of services/supports they are receiving. Factors such as actual attendance in residential and day programs, fluctuations in use of services (such as PCA and nursing), and delays in direct billings to Medicaid make providing actual costs on a routine basis difficult. The DDSN standardized Microsoft Excel spreadsheet to compute an estimated cost of services is available for use or a provider may use a spreadsheet approved by DDSN Finance. The estimate of the cost of services will generally be prepared by the SC with any additional cost data provided by the Finance Director of the provider. The provider can opt to have other staff prepare the cost estimate to give to the SC. (Refer to Memo dated 8/29/06 from the DDSN Director of Cost Analysis for specific instruction or contact the Office of the Director of Cost Analysis.) Information regarding abuse, neglect, and exploitation will be provided by Service Coordination providers annually for all people receiving Level I Service Coordination explaining who is a vulnerable adult, what is abuse, neglect, and exploitation and providers' phone numbers of where to report suspected abuse cases if they occur in a community setting or in a facility.
E. MONITORING OR FOLLOW UP (CORE FUNCTION) **1.** At least quarterly, the Plan must be monitored to ensure: a. services are received and are effective b. person/legal guardian is satisfied c. that the Plan continues to be appropriate to address needs **2.** The person's access to a	MONITORING/CONTACT: Assessment of service quality, service effectiveness and satisfaction are fundamental elements of monitoring. Monitoring and contacts for other reasons may occur through home visits, face-to-face contacts, mail correspondences, email or telephone calls with the person receiving services, legal guardian, family, natural supports and providers of services and supports received. Beginning November 2, 2010, monitoring forms will be electronically signed, titled, and dated. The Best Practice (not mandatory) for frequency of contacts

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primary health care provider and other health care providers is monitored as needed based on the person's health care needs **3.** For those on Level I Service Coordination, face-to-face contact between the Service Coordinator and the person must occur at least once every 365 days where the person is in their normal environment. **4.** The rate and intensity of monitoring/contact is determined based on the skills, abilities and resources available to the person. **5.** Quarterly monitoring must be done in consultation with the person being served and/or their legal guardian. **6.** The quarterly plan reviews will note any progress or lack of progress towards meeting needs that are on the plan .	with the consumer and/or legal guardian, parent or representative is at least once every 60 calendar days. The best practice for frequency of face to face contact with the consumer and/or legal guardian, parent, or representative is at least once every 180 calendar days in the consumer's normal environment. **QUARTERLY PLAN REVIEW** – In order to ensure the Plan continues to meet the person's current personal goals and needs, it must be continually monitored throughout the year and must be formally reviewed on a quarterly basis. One review will occur at the time of plan completion, and the others will be completed by the last day of each third month following the plan date. Quarterly plan reviews will be completed using the CAP module of CDSS. Monitoring other than that required in CAP during quarterly plan review may be documented in the service notes as long as the same content is considered. Service notes also should be used to document any information/observations that could not be included on the CAP monitoring form, Plan reviews will consist of reviewing all current needs to determine if interventions identified to meet goals/needs have been implemented, if interventions were useful and effective, and if the person receiving services/legal guardian is satisfied with the interventions/services and the provider of services. Effectiveness or progress towards meeting a need on the plan should be noted in the "Comments" section of the CAP monitoring form or in a corresponding service note. As these reviews occur, expressed personal goals and preferences of the person/legal guardian will be considered. If any changes/revisions need to occur as a result of the review, the Plan must be updated (using the CAP module of CDSS) to include an explanation of the change/update. When the Service Coordinator contacts the person, their legal guardian and/or family, direct service providers, and others, the Service Coordinator will be attentive to health and safety issues that may impact or are impacting the person. These issues should be addressed as appropriate. Any contacts made with program providers or family in previous months during a quarter may be referenced as part

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	of the full quarterly review at the end of the quarter without having to contact each provider or family member again. **MONITORING COMPONENTS** – Monitoring of services/quarterly plan reviews should include the following components: (It is not required that each component be included for every contact, although all components should be included with each quarterly review.) • Continue to address the changing circumstances of the person, particularly those which support health and safety. • Services and supports must be monitored to ensure they are implemented as agreed upon in the Support Plan and continue to be appropriate and effective. • Services and supports must be monitored to ensure service quality and to ensure that the person receiving the service or legal guardian continue to be satisfied with services and providers. • Services and supports must be monitored to ensure they are meeting the needs of the person as evidenced by observable or documented progress. People receiving Level I Service Coordination by definition require more intensive and ongoing Service Coordination services. People receiving Level II Service Coordination do not have a current plan and do not require an intensive level of Service Coordination involvement. Therefore, they will not require any service coordination monitoring. Note: DDSN HCB Waivers have specific monitoring requirements in order to ensure continued access to Medicaid-funded services. Please refer to specific waiver manuals/guidelines for monitoring waiver services.
F. ADVOCACY 1. The Service Coordinator must advocate on behalf of the person to help ensure his or her equal access to existing services and to encourage the development of	A service coordinator may need to advocate on behalf of persons served by the qualified provider by whom the service coordinator is employed. This is particularly true in circumstances of possible abuse, neglect, or other potential threats to health and safety. Advocacy is the supporting of basic human and civil rights

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services needed by the person that do not exist in his or her community. 2. The Service Coordinator must help ensure that all human and civil rights are maintained for the persons they serve.	of people served and families and assuring fair and equal access to environments and any necessary services. Advocacy involves influencing human service systems to respond to needs or to documented deficiencies in the service delivery systems. This advocacy may include recommending and facilitating a person's movement from one program area to another or from one agency to another and participating in other agencies' planning processes as appropriate. As problems are identified, the Service Coordinator must advocate on behalf of the person to assure access to adequate health care and a clean and safe living environment. QUALITY OF SERVICES – The Service Coordinator will advocate as necessary with current or potential service providers to assure the person's identified personal goals and needs are addressed, and that services are being provided to the person's satisfaction. PEOPLE'S RIGHTS – As necessary, the Service Coordinator will advocate on behalf of the person receiving services to help ensure basic human and civil rights in all areas of life including residential, vocational, legal, medical, educational, recreational, etc. EDUCATIONAL RIGHTS – With the approval of the person/legal guardian, the Service Coordinator will advocate on behalf of the person receiving services in the educational setting, as applicable, to ensure that all needs are being met and services are being provided as identified in the Individualized Education Plan (IEP). The Service Coordinator should work collaboratively with the person, legal guardian and school personnel to assure the appropriate education in the least restrictive environment and make referrals, when appropriate, to advocacy groups such as Pro-Parents.

III. RECORD KEEPING AND DOCUMENTATION

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A. A primary case record will be maintained for each person receiving services. **B.** The primary case record must follow a File Index as determined by the provider agency. **C.** As appropriate records will include, but are not limited to, the following: **1.** Assessment Information (including the SCDDSN Service Coordination Annual Assessment and any Level I/II Assessment) **2.** Current Plan and previous year's plan in paper or electronic format as applicable (If receiving Level I Service Coordination). The paper file will identify records that are maintained electronically. **3.** Level II Agreement (If receiving Level II Service Coordination and the assignment was not a result of 90 calendar days in intake or eligibility determination.) **4.** Initial Social History Assessment (CIS) and updates (If applicable) **5.** Medical information as applicable and when available **6.** Psychological Assessment, if applicable **7.** IEPs, IFSPs, FSPs, if applicable by age **8.** Eligibility Letter (after 1988) **9.** Valid Service Agreement **10.** Contact/Service Notes in paper or electronic format as applicable The paper file will indicate records that are maintained electronically.	**SEE IMPORTANT NOTE REGARDING RECORDS ON PAGE 8, GUIDANCE** Case records (paper files and electronic records) maintained by the Service Coordinator are considered to be the person's primary case record with DDSN. Primary case records should be logically and consistently organized such that the identification of needs, referrals, follow-up, plan development and monitoring can be easily and clearly reviewed, copied, and audited. Service Coordination providers will have the flexibility to use the filing system of their choice (i.e. six-section divided files, 3-ring binders, etc.) Service notes should provide a clear/concise description of the circumstances being recorded. The contents should be current, complete, timely, and meet documentation requirements. Documentation and record organization should also permit someone unfamiliar with the person receiving services to quickly assume knowledge sufficient to provide Service Coordination, or to review the records to assure compliance with contracts, policies, standards and procedures. Purged record contents should also be maintained according to the provider agency's File Index and in close proximity to the primary case record. HASCI Waiver recipient's files must follow the HASCI Waiver index (refer to the HASCI Waiver Manual).Closed records and backup records will also be retained according to the provider's primary case record index. Closed case records must be retained for a period of no less than 6 years after the end of the annual contract period. If any litigation, claims or other actions involving the records are initiated prior to the expiration of the 6 year period, the records must be retained until completion of the actions and resolution of all issues which arise from it, or until the end of the required period whichever is later. (For more detailed information regarding record retention, please refer to the Individual Service Delivery Records Management Policy, #368-01-DD.

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11. HIPAA Acknowledgement **12.** Acknowledgement of SC/EI Choice (when required) **13.** Correspondence, including emails, and any other documentation intended to support Medicaid reimbursement for Service Coordination **14.** Legal records determining competency or determining a change in legal guardianship or documenting a legal name change, if applicable **15.** Information from other service agencies providing services to the person **16.** Other documents which from time to time may be deemed essential by DDSN or the state Medicaid agency	Waiver Forms such as: b. Waiver enrollment and disenrollment forms c. Waiver budget information d. **ALL** Level of Care forms e. Freedom of Choice form f. Waiver Acknowledgement of Choice form g. Waiver Acknowledgement of Rights and Responsibilities form h. Waiver authorization and termination forms i. Other Waiver forms as required in the PDD, MR/RD, CS, and HASCI Waiver manuals The above list is not all-inclusive.
D. For participants who are enrolled in a SCDDSN operated HCB Waiver; the person's record contains the required forms as outlined by the Waiver manual.	
E. The primary case record including the electronic assessment, planning, monitoring and service note system will be kept secure according to DDSN and HIPAA security, confidentiality and privacy policies.	Refer to SCDDSN Directives: 167-06-DD, Confidentiality of Personal Information 368-01-DD, Individual Service Delivery Records Management 367-12-DD, Computer Data Security
F. Service notes must document all Service Coordination activity on behalf of the specific person represented by the primary case record and, upon review, must justify the need for service coordination. Notes will include the following if a reportable core function activity is being	Multiple actions which support the same activity and which occurred on the same day may be incorporated into a single service note provided all necessary information is included and is clear to any other readers or reviewers. Activities done by the Service Coordinator such as written correspondence, completed reports and completion/updates to the Support Plan must be documented in service notes to include identification and location in the record of any referenced

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documented: **1.** Name and title of person being contacted **2.** Type of contact **3.** Location of contact **4.** Purpose of contact **5.** Intervention or services provided **6.** The outcome **7.** Needed follow-up	documents. It is **not** necessary to document receipt of program reports, correspondence, etc. **unless** the Service Coordinator is reviewing these for the purpose of monitoring. The presence of the documents in the record itself will serve as documentation of their receipt. (Note: Service notes stating that "SC received and reviewed progress notes" will **NOT** be acceptable for reporting purposes. If progress notes are reviewed for the purpose of monitoring a service, documentation should include details regarding progress toward goals, consumer satisfaction, etc. and not just reference the completed monitoring form.)
G. All service notes must: 1. be completed on CDSS beginning July 1, 2010 2. be completed within five (5) business days of the activity/event being documented 3. be completed on CDSS so that activities may be reported to DDSN for billing 4. be labeled as a "Late Entry" when the service coordinator is not able to complete a note within 5 business days from the time that the activity occurred 5. Be completed by someone credentialed to be a service coordinator if entered electronically.	The Best Practice (not mandatory) is to complete service notes on the day that a service or activity is rendered. Service notes on CDSS are the electronic record of core functions performed by the service coordinator. The service note module of CDSS is in accordance with the Uniform Electronic Transactions Act (S.C. Code Ann. 26-6-10 et seq.) When a service note for a core function activity is completed on CDSS, it is automatically transmitted to DDSN for possible billing. If a note is "Saved" (not completed), the note is still in progress and will not be reported to DDSN for possible billing. Service notes completed on CDSS do not have to be printed and placed in the primary case record. Any manually signed service notes written by a service coordination assistant prior to July1, 2010 must be co-signed by a credentialed service coordinator. TRANSFER OF FILES: When a transfer must be made to a different SC/EI provider, the following steps should be followed to prevent any disruption in services: The sending Service Coordination provider should: • Get the Acknowledgement of SC/EI Choice form signed. If the chosen new provider is the DSN Board of the county of residence, the DSN Board must accept the transfer. If the chosen new provider is an approved private provider or DSN Board outside the home county, the new provider must accept the transfer before it is made. The sending provider should always alert the chosen provider by email

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	or phone or fax before transferring the record on CDSS. If a person independently contacts/chooses another provider or if any circumstances prohibit the sending provider from doing so, the receiving provider/SC will get the Acknowledgement of SC/EI Choice form signed. • Contact receiving Service Coordination provider to discuss the logistics of transferring, discuss services and providers, and set a date for mailing the case record and transfer on CDSS. All items below the asterisk line must be completed within 10 business days of the transfer on CDSS. ********** • Reconcile waiver budget to close out services Complete any outstanding service notes. • Update/change CDSS as needed • Review case record with SC Supervisor • Terminate services, if necessary, and notify all service providers (Note: Service termination may not be necessary when the person is not moving out of the immediate area or is choosing a different SC provider) • Copy the case record and maintain a copy of all records of service according to 368-01-DD, Individual Service Delivery Records Management • Send originals of the paper case record to the receiving Service Coordination provider. The receiving Service Coordination provider should: • Ensure that the home board provider on the CDSS (county to county transfers only) is correct. • Notify SCDDSN Cost Analysis Division to set up a new waiver budget (waiver recipients only) • Update budget and services on the CDSS (For waiver recipients, complete new waiver budget within 20 business days of transfer on CDSS) • Contact chosen providers and authorize services if necessary • Update existing plan or complete a new plan as necessary • Organize all case record information and insert into a file.
H. All manual service notes must be typed or handwritten in black or dark blue ink.	Electronic service notes can only be typed and printed in black.

Standards	Guidance
I. All service notes must be legible and kept in chronological order according to the date of entry.	Any notes done out of chronological order should be labeled as "Late Entry". If a provider chooses to print electronic service notes for the primary case record and for non-electronic service notes, late entries must be filed according to the date they were completed, not on the date of the activity that is described in the notes.
J. All manual and electronic service notes must be dated and legibly signed with the Service Coordinator's name or initials, professional title, and dated.	Non-electronic service notes must be manually signed by a service coordinator. When a review of non-electronic service notes reveals that a service note was not signed when written, the note must be signed immediately by a credentialed service coordinator and that signature given the current date. A current service note must be written to explain the difference between the signature date and the date the note was actually written. If the activity described in the unsigned note was previously reported on the Service Provision Log (SPL), this is **NOT** considered a reporting error that must be corrected. If initials are used with manually signed documents, these must be included on a signature sheet maintained at the Service Coordination provider's office. Service coordination staff is given exclusively assigned pin numbers as electronic signatures to validate an electronic assessment, plan, monitoring, and service note as a genuine and true reflection of service coordination activity. Electronic signatures will be placed at appropriate locations on electronic documents and will be recognized by the phrase "Electronically signed by…". The date that the document was signed will also appear along with the title of Service Coordinator. Pin numbers may be obtained by contacting the Help Desk of DDSN's IT Department.
K. If a service is reported for billing during a given month, there must be a service note documenting the performance of a reportable activity during that month.	For non-electronic service notes when no documentation is present in the record during a month in which a service is reported on an SPL, this IS considered a reporting error that must be corrected. Completed electronic service notes and the reporting of those notes for billing purposes are automatically linked in the electronic service note system. There is no separate manual service reporting process for electronic service notes.
L. A list of any abbreviations or symbols used in the records must be maintained.	This list must be clear as to the meaning of each abbreviation or symbol, and only abbreviations and symbols on this approved list may be used.
M. Any person(s) referenced in service notes or any supporting	Identify person(s) in service notes by their full name and title or relationship to the person. References in service notes must be

Standards	Guidance
correspondences must be identified in each entry.	done at least one time for each entry/service note.
N. Errors in service notes are corrected appropriately.	When an error is made in a non-electronic service note, the Service Coordinator should clearly draw one line through the error, write "error" to the side in parentheses, enter the correction, and add the Service Coordinator's signature or initials and date. If additional explanation about the correction is appropriate, this must also be included in a service note. The information contained in the error must remain legible, and no correction fluid or erasable ink may be used. When an error is made in an electronic service note, the Service Coordinator will follow error correction procedures identified in the system as "Revision to the Completed Service Note". The corrected service note and the previous incorrect note for a specific person may be seen together in "Print/View History" when the original service note date is clicked on CDSS.
O. Service notes must be individualized to the specific person represented by the primary case record.	A single identical service note cannot be used to document activity about 2 or more consumers.

IV. Service Reporting

Standards	Guidance
When a core function service coordination activity is reported on SPL for billing, there must be a service note documenting the performance of a reportable activity. Electronic service notes intended to document core function activities should be sufficient in content to support billing to Medicaid. **(Reference III Recordkeeping and Documentation, Item F.)**	Reportable Service Coordination activities must represent at least one of the four core job functions which were previously defined in Chapter 1 of this manual. These core job functions are the primary activities/duties Service Coordinators perform. Activities which fall within the definition of one of these categories of services are the only activities Service Coordinators may report. **No activities on behalf of those on Level II service coordination should be reported on the SPL. However, all core function and non-reportable activities for persons on Level II should be documented in service notes.** Service Coordinators may back-report for any

Standards	Guidance
	activities for which a 'Late Entry' service note is completed for a period of up to 12 months after the date the activity actually occurred. INITIAL REPORTING No service coordination activity is reportable on SPL until a case is opened on CDSS and until a Service Agreement form is signed regardless of the number of service notes or the type of activity that they describe. Electronic service notes, including core function and non-reportable activities may be entered as soon as the person is assigned to a service coordinator as DDSN will determine whether Medicaid may be billed. SUPPORT PLAN Service Coordination activity may be reported on SPL's only when a current Support Plan is in place or when a plan is in process according to established timeframes. If a plan is not in place or not in process within established time frames, the activity must be reported on the SPL as non-billable. PERSON/APPLICANT NOT LOCATED – If a DDSN applicant or DDSN eligible person is missing and his/her whereabouts cannot be determined within 30 calendar days, service coordination activity must not be reported on the SPL until that person is located. Reporting on SPL must be discontinued after 30 calendar days from the date the Service Coordinator is made aware of the person missing, not the actual date the person went missing. After 30 calendar days, all service coordination activity is not reportable on the SPL until such time as the person is located and documented by a service note. As mentioned previously, core function and non-reportable electronic service notes may be entered at any time. SERVICE PROVIDER REPORTS – The reading or reviewing of reports from service providers in and of itself is not reportable on SPL and is not considered a core function for electronic notes.

Standards	Guidance
	Service notes should document the reviewing of reports for the purpose of identifying needs or monitoring services or progress toward identified goals in order for this activity to be reportable on the SPL or to represent a core function in electronic notes. **RTF/IMD and ICF/MR Placement** For people in Residential Treatment Facilities (RTF)/Institutions for Mental Disease (IMD) such as New Hope, Charter, Patrick B. Harris Psychiatric Hospital, and S.C. State Hospital, the SCDHHS case management hierarchy must be followed. (Please refer to the complete copy of the SCDHHS case management hierarchy at the end of this document.) Service Coordination services are limited to: (a) assuring that a placement continues to be necessary and appropriate to meet the person's needs and (b) planning for future placement. Reportable activities may include: • Assessment of treatment or placement needs on an ongoing basis to ensure that the person continues to require the RTF/IMD level of care. • Participation in treatment planning meetings, IEP meetings or other agency (RTF/IMD) program or service planning meetings. • Planning for future placement(s), assuring that a placement is appropriate to meet individual needs and is the least restrictive placement possible. • Contact or consultation with other agencies or providers to assure appropriateness of a placement. • Crisis assessment and referral services when a placement disrupts. • Case management services which are required to maintain a person in a temporary alternative placement. • Activities to gather information for an ICF/MR Level of Care with the intention of obtaining ICF/MR placement or waiver

Standards	Guidance
	services. • Activities related to transition and discharge planning for someone within 180 calendar days of discharge from an ICF/MR or other institutional setting. RESIDENTIAL and ALTERNATIVE PLACEMENTS : There are no Service Coordination SPL reporting restrictions (as there are for RTF/IMD placements) for individuals in DDSN residential placements and DDSN funded alternative (out-of-home) placements such as supervised independent living, high and moderate management group homes, specialized treatment services for sexual offenders, therapeutic foster care providers, and intensive crisis care. The SCDHHS case management hierarchy at the end of this document must be followed. **EXAMPLES OF <u>NON-REPORTABLE</u> ACTIVITIES** A variety of 'non-Service Coordination' activities, which commonly occur in a normal work environment, may be required of a Service Coordinator or other provider agency staff, but are not reportable. These types of activities are very important in providing quality person-centered services for individuals and families, but do not fit into the definition of one of the four core job functions and therefore are not reportable. The following activities are <u>not</u> reportable on the SPL or electronically and are administrative in nature: • Prior authorization for Medicaid services • Referral and monitoring of one's own activities • Completion of any requested information regarding consumers for the provider, public agencies or other private entities for administrative purposes • Participation in recreation or socialization

Standards	Guidance
	activities with the consumer or his/her family • Activities performed for the person, such as shopping or errands • Contacts solely for the purpose of medication or appointment reminders • Activities on behalf of deceased individuals or their families. • Verification of Medicaid numbers. • Medicaid eligibility determinations and re-determinations. (Activities on behalf of TEFRA Medicaid applicants seeking ICF/MR Level of Care are <u>not</u> reportable as this is part of a Medicaid eligibility process.) • Transportation of individuals or family members for any purpose. (Service Coordinators may perform reportable activities, such as monitoring, while transporting and these are reportable.) • <u>Attempted</u> reportable activities which were never completed. (The attempt should be documented in service notes.) • Review of an individual's primary case record (such as might occur when the individual is new to a caseload). • Provision of information about an individual for administrative purposes (such as during a contractual compliance review). • Participation in recreational or social activities with the individual or family. • Activities rendered during court proceedings (South Carolina Family Court, General Sessions Court, or Federal Court) which are convened to address criminal charges against the individual, custody or other judicial matters by the person or others. • General activities with individuals in institutional settings (such as ICF/MRs, adult correctional facilities, juvenile reception and evaluation centers or correctional facilities). An exception is

Standards	Guidance
	made when a person is within 180 calendar days of discharge from an ICF/MR or other institutional setting. Activities related to transition and discharge planning are billable if the person is Level I. • The act of writing service notes. • Completing statistical reports. • Clerical activities such as typing, copying, faxing and filing. • Composing form letters not personalized to the individual. • Completing forms for DDSN Family Support funding. (However, discussion with the individual/legal guardian regarding the request and the gathering of information to support the request may be reportable.) • Services to a hospice recipient unless a prior authorization number has been obtained from the hospice provider. • Performing duties of a day or residential staff as a result of their unplanned absence. • Fund-raising activities. • General office management. • Management of agency vehicles. • Serving on DSN Board committees or inter-agency workgroups. • Any activities on behalf of individuals receiving Level II Service Coordination.

V. Case Management Overlap

Standards	Guidance
A. When more than one case management provider is providing services, services must be provided in accordance with The Medicaid Case Management Overlap and Hierarchy.	Refer to Case Management Hierarchy Guidelines at the end of this document.

MEDICAID CASE MANAGEMENT OVERLAP AND HIERARCHY

These case management and hierarchy guidelines of the Department of Health and Human Services are intended to assist Service Coordinators in understanding their roles and their service reporting responsibilities when a DDSN consumer has multiple Medicaid-funded case managers.

CASE MANAGEMENT OVERLAP

Some individuals who are dually diagnosed or have complex social and/or medical problems may require services from more than one case management provider to be successfully managed and/or integrated into the community. The needs and resources of each individual may change over time as well as the need for case management services from another provider. Case management providers must work closely and cooperatively if the recipient's needs are to be adequately met and duplication of services and Medicaid payments are to be avoided. A system must exist within each case management program to assure that service providers are communicating, coordinating care and services, and adequately meeting individual needs

CASE MANAGEMENT HIERARCHY GUIDELINES

A Primary Targeted Case Manager as well as a secondary provider for each overlapping situation must be determined. The Primary Case Manager shall: a) ensure access to services, b) arrange needed care and services, c) monitor the case on an ongoing basis, d) provide crisis assessment and referral services, e) provide needed follow-up, and f) communicate (by telephone or face-to-face) regularly with other involved agencies/providers.

Concurrent Care shall be rendered to an individual to which another provider has been designated the Primary Case Manager. The Concurrent Care provider shall, in a timely manner, notify the Primary Case Manager about: a) changes in the individual/family's situation they have identified, b) needs, problems or progress, c) required referrals, and d) treatment/service planning meetings. The Concurrent Care provider will render different, distinctive types of services from the Primary Case Manager. Billing is restricted to specific activities.

Concurrent service providers will render treatment related, case management-like services. Ancillary Services procedure codes have been set up for concurrent service providers.

If overlap occurs, these guidelines shall be followed:

CCEDC/IFCCS: Overlap between these two programs is not permissible, except when cases are transitioning between the two agencies

DMH/IFCCS: IFCCS primary case manager with DMH providing concurrent care

DJJ/IFCCS: IFCCS primary case manager with DJJ providing concurrent care

CCEDC/Sickle Cell: CCEDC primary case manager with Sickle Cell providing concurrent services.

CCEDC/DDSN Service Coordination: CCEDC primary case manager with DDSN providing concurrent care.

CCEDC/DDSN Early Intervention (EI): CCEDC primary case manager with EI providing concurrent care.

CCEDC/DMH: CCEDC primary case manager with DMH providing concurrent services.

CCEDC/DAODAS: CCEDC primary case manager with DAODAS providing concurrent services.

CCEDC/CLTC: CLTC primary case manager with CCEDC providing concurrent care.

CCEDC/SCSDB – Commission For Blind: CCEDC primary case manager with SCSDB – Commission for Blind providing concurrent care.

CCEDC/DJJ: CCEDC primary case manager with DJJ providing concurrent care.

DDSN Service Coordination/DDSN Early Intervention: Overlap is not permissible.

DDSN/IFCCS: IFCCS primary case manager with DDSN providing concurrent care.

DDSN/DMH: DDSN primary case manager with DMH providing concurrent services.

DDSN/DAODAS: DDSN primary case manager with DAODAS providing concurrent services.

DDSN/Sickle Cell: DDSN primary case manager with Sickle Cell providing concurrent services.

DDSN/SCSDB – Commission For Blind: SCSDB – Commission for Blind primary case manager with DDSN providing concurrent care.

DDSN/CLTC: CLTC primary case manager with DDSN providing concurrent care. DDSN primary case manager for children (0 to 18) receiving CLTC Personal Care Aide Only services.

DDSN/ DSS Adult Services: DDSN primary case manager with DSS providing concurrent care.

DDSN/DJJ: DDSN primary with DJJ providing concurrent care.

DDSN Early Intervention/DMH: DDSN primary case manager with DMH providing concurrent services.

DDSN Early Intervention/DAODAS: Overlap not anticipated.

DDSN Early Intervention/Sickle Cell: DDSN primary case manager with Sickle Cell providing concurrent services.

DDSN Early Intervention/SCSDB – Commission For Blind: SCSDB primary case manager with DDSN providing concurrent care. DDSN primary case manager with Commission for Blind providing concurrent care.

DDSN Early Intervention/CLTC: CLTC primary case manager with DDSN providing concurrent care.

DDSN Early Intervention/DSS IFCCS: DDSN primary case manager with DSS providing concurrent care.

DMH/DJJ: DMH primary case manager with DJJ providing concurrent care

KEY:

CCEDC = Continuum of Care for Emotionally Disturbed Children
CLTC = Community Long Term Care
DAODAS = Department of Alcohol and Other Drug Abuse Services
DDSN = Department of Disabilities and Special Needs
DJJ = Department of Juvenile Justice
DMH = Department of Mental Health
DSS = Department of Social Services
IFCCS = Intensive Foster Care and Clinical Services
SCSDB = South Carolina School for the Deaf and the Blind

OTHER CRITERIA/SPECIAL RESTRICTIONS

1. Each provider shall be responsible for: a) attempting to identify during the intake process whether an applicant is already receiving case management services from another Medicaid provider and b) notifying any other involved Medicaid case management providers of an applicant's request for services.

2. Each provider must bill Medicaid according to Case Management Hierarchy Guidelines for each individual receiving case management services from another Medicaid provider.

3. Needed services should never be denied to an individual because another provider has been designated the Primary Case Manager.

4. Each provider shall timely notify other involved agencies or providers if an individual in an overlapping situation terminates their services.

EXCEPTIONS TO THE HIERARCHY/RESOLUTION PROCESS

Each provider is encouraged to resolve any exceptions to the Case Management Hierarchy at the local level. When an exception exists, these guidelines must be followed:

1. If a Concurrent Care provider is predominantly meeting the treatment and service needs of the individual OR if the Primary Case Manager has failed to adequately coordinate care and services, the Concurrent Care provider provider may initiate contact with the Primary Case Manager at the local level to request a change in the Primary Case Manager. A meeting should be set up between the two agencies to discuss the feasibility of a change in the Primary Case Manager.

2. Contacts (telephone or face-to-face) between the Concurrent Care provider and the Primary Case Manager concerning a change in Primary Case Manager as well as the final determination of a Primary Case Manager must be documented in each provider's case management record. Although documentation of these activities is required, the activities are administrative and are not reimbursable by Medicaid.

3. If the state agency or main office administrators are unable to reach a determination of the most appropriate Primary Case Manager, the case should be referred to the Department of Health and Human Services for review.

4. The Department of Health and Human Services may make the determination of the most appropriate Primary Case Manager or may request that a team of other agency representatives make the determination.

5. The involved Medicaid providers will be notified within forty-five (45) days after the case is received by the Department of Health and Human Services whether a change in the primary case manager is warranted.